Accountable Health Communities (AHC) Model Fact Sheet

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Overview
Many of the biggest drivers of health and health care costs are beyond the scope of health care alone. Health-related social needs often are left undetected and unaddressed. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individuals' ability to manage these conditions, increase health care costs, and lead to avoidable health care utilization.

The Centers for Medicare & Medicaid Services (CMS) has announced an Accountable Health Communities (AHC) model to address a critical gap between clinical care and community services in the current delivery system. The AHC model will test whether increased awareness of and access to services addressing health-related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities.

Background
The Accountable Health Communities Model is authorized under Section 1115A of the Social Security Act (added by section 3021 of the Affordable Care Act), which established the Center for Medicare and Medicaid Innovation (the Innovation Center) to test innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid, and Children's Health Insurance Program expenditures while maintaining or enhancing the quality of beneficiaries' care.

Purpose
The foundation of the Accountable Health Communities Model is universal, comprehensive screening for health-related social needs of community-dwelling Medicare and Medicaid beneficiaries accessing health care at participating clinical delivery sites. The model aims to identify and address beneficiaries' health-related social needs in at least the following core areas:

- Housing instability and quality,
- Food insecurity,
- Utility needs,
- Interpersonal violence, and
- Transportation needs beyond medical transportation.

Over a five-year performance period, CMS will implement and test a three-track model based on promising service delivery approaches:

- **Track 1** – Awareness: Increase beneficiary *awareness* of available community services through information dissemination and referral
- **Track 2** – Assistance: Provide community service navigation services to *assist* high-risk beneficiaries with accessing services
- **Track 3** – Alignment: Encourage partner *alignment* to ensure that community services are available and responsive to the needs of beneficiaries

Accountable Health Communities Model Structure

	Track 1: Increase Awareness	Track 2: Provide Assistance	Track 3: Align Partners
Target Population	Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social needs	Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social needs	Community-dwelling Medicare & Medicaid beneficiaries with unmet health-related social needs

Short Description	Referral only	Community service navigation	Community service navigation and partner alignment
Question Being Tested	Will increasing beneficiary **awareness** of available community services through information dissemination and referral impact total health care costs, inpatient and outpatient health care utilization, and health and quality of care?	Will providing community service navigation to **assist** high-risk beneficiaries with accessing community services to address certain identified health-related social needs impact their total health care costs, inpatient and outpatient health care utilization, and health and quality of care?	Will a combination of community service navigation (at the individual beneficiary level) and partner **alignment** at the community level impact their total health care costs, inpatient and outpatient health care utilization, and health and quality of care?
Intervention	**Inventory** of local community services responsive to community needs assessment **Universal screening of all Medicare & Medicaid beneficiaries** who seek care from participating clinical delivery sites **Referral** to community services for beneficiaries with certain identified unmet health-related needs in intervention group[1] with beneficiaries responsible for completing referral	**Inventory** of local community services responsive to community needs assessment **Universal screening of all Medicare & Medicaid beneficiaries** who seek care from participating clinical delivery sites **Referral** to community services *and* intensive **community service navigation** (in-depth assessment, planning and follow-up until needs are resolved or determined to be unresolvable) of high-risk beneficiaries with certain identified unmet health-related needs in the intervention group	**Inventory** of local community services responsive to community needs assessment **Universal screening of all Medicare & Medicaid beneficiaries** who seek care from participating clinical delivery sites **Referral** to community services *and* intensive **community service navigation** (in-depth personal interview, planning and follow-up until needs are resolved or determined to be unresolvable) of high-risk beneficiaries with certain identified unmet health-related needs in the intervention group **Continuous quality improvement** approach including an advisory board that ensures community services are available to address health-related social needs, and data sharing to inform a **gap analysis** and quality improvement plan
Funding Categories	Start-up funds Payments for screening and referral of Medicare/Medicaid beneficiaries who seek care from participating clinical delivery sites	Start-up funds Payments for screening and referral of Medicare/Medicaid beneficiaries who seek care from participating clinical delivery sites Payments for each high-risk beneficiary in the intervention group that elects to receive community service navigation services	Start-up funds Payments for screening and referral of Medicare/Medicaid beneficiaries who seek care from participating clinical delivery sites Payments for each high-risk beneficiary in the intervention group that elects to receive community service navigation services Annual lump sum payments to support quality improvement activities
Evaluation	Randomized design	Randomized design	Two matched comparison groups
Number of award recipients	Up to 12	Up to 12	Up to 20

[1]Beneficiaries who identify a health-related social need will be stratified based on emergency department utilization history and randomized to an intervention or control group. Beneficiaries assigned to the intervention group will receive a tailored community referral summary. Beneficiaries assigned to the control group will not receive a tailored community referral summary (developed via the AHC model); instead, they will receive usual care.

Funding
Funding will go to consortiums led by bridge organizations or to bridge organizations that intend to form consortiums responsible for implementing the model. CMS will support up to 44 cooperative agreements. The total amount of federal funds to implement interventions is anticipated to be:

- Up to $1 million to each of 12 Track 1 – Awareness Intervention award recipients;
- Up to $2.57 million to each of 12 Track 2 – Assistance Intervention award recipients; and,
- Up to $4.51 million to each of 20 Track 3 – Alignment Intervention award recipients.

CMS funds for this model cannot be used to pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, and transportation) received by beneficiaries as a result of their participation in any of the three intervention tracks.

Evaluation
The purpose of the Accountable Health Communities evaluation is to test the impact of the Accountable Health Communities interventions on total health care costs and inpatient and outpatient health care utilization, as well as health and quality of care for Medicare and Medicaid beneficiaries. CMS will test whether community referral, community service navigation, or community service alignment impacts total cost of care, emergency department visits, inpatient hospital admissions, and quality of care for high-risk Medicare and Medicaid beneficiaries. The model evaluation will include randomization for Track 1 – Awareness and Track 2 – Assistance and matched comparison groups for Track 3 – Alignment. Track 3 will also evaluate the degree to which award recipients have realigned community resources to match the needs of the target population and the degree to which community resource gaps have closed.

Eligible Applicants
Eligible applicants are community-based organizations, health care practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities with the capacity to develop and maintain a referral network with clinical delivery sites and community service providers. Applicants from all 50 states, U.S. Territories, and the District of Columbia may apply.

Application Process
Interested applicants must submit a letter of intent by February 8, 2016. Applications must be submitted electronically no later than 1:00 p.m. EST on March 31, 2016. Applicants may apply to participate in one or two tracks, but successful applicants will be selected to participate in a single track only. CMS anticipates announcing cooperative agreement awards in the fall 2016.

Additional Information
For more information or to submit a letter of intent, please refer to the Accountable Health Communities Funding Opportunity Announcement found at: https://innovation.cms.gov/initiatives/ahcm.

For specific questions not answered in this fact sheet or the Funding Opportunity Announcement, please send an email to AccountableHealthCommunities@cms.hhs.gov.

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